Mutual Agreement

RI Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 www.dlt.ri.gov/wc
Phone 401-462-8100 Fax 401-462-8105

Claim Administrator Claim Number

Employee Information			Employer, Insurer & Claim Administrator
SSN or ID	Date of Birth		Employer Business Name
Last Name	First Name	Initial	Insurer Business Name
Date of Injury	Date of Death		Claim Administrator Business Name

This form may be used under RIGL § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree on a workers' compensation claim. This form cannot be used to start or end weekly benefits.

Amendment to Memorandum of Agreement. Indicate the change.

- ☐ Change employee's marital status to ☐ Single ☐ Married effective date:
- ☐ Change the total average weekly wage to $ effective date:
- ☐ Change the weekly spendable base wage to $ effective date:
- ☐ Change the weekly compensation rate to $ effective date:
- ☐ Change maximum number of eligible exemptions to effective date:
- ☐ Change number of dependents to effective date:
- ☐ Modify from total to partial incapacity effective date:
- ☐ Modify from partial to total incapacity effective date:
- ☐ Suitable Alternative Employment (offer attached) effective date:
- ☐ Change nature of injury and/or affected body part to
- ☐ Other (specify)

Specific Injury Agreement

The injured worker and the Claims Administrator representing the Insurer and Employer agree on the specific injury or injuries stated here.

Disfigurement: Body Part	Weeks	Weekly Rate	Amount Paid	Date Paid

Loss of Use: Body Part	Percent	Weeks	Weekly Rate	Amount Paid	Date Paid
	0.00%				
	0.00%				

Body Part	Type of Hearing Loss		Percent	Weeks	Weekly Rate	Amount Paid	Date Paid
☐ Left	☐ Occupational	☐ Traumatic	0.00%				
☐ Right	☐ Occupational	☐ Traumatic	0.00%				
☐ Both	☐ Occupational	☐ Traumatic	0.00%				

Signatures of Parties to this Agreement

Employee Signature	Date	Claim Adjuster Signature	Date

A Mutual Agreement is a legal document that memorializes an agreement between the parties to change a Memorandum of Agreement as specified in RIGL § 28-35-6(b). A copy is provided to each party and filed with RI Department of Labor and Training.

Claim Administrator Claim number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

Employee information:

- SSN or ID: provide at least the last 4 digits of the employee's social security number or the employee ID number assigned by DLT. DO NOT use a fictitious number.
- Date of birth: please enter the employee's date of birth.
- Name: enter the employee's last name, first name and middle initial.
- Date of injury: enter the date of the injury or start of illness.
- Date of death: if the employee has died, enter the date of death.

Employer, Insurer and Claim Administrator information:

- Employer Business Name: enter the name of the employer's business.
- Insurer Business Name: enter the name of the licensed insurance company or self-insured employer.
- Claim Administrator: enter the business name of the company handling the claim.

Amendment to Memorandum of Agreement.

- Indicate the agreed upon changes using the options listed on the form.
- Provide complete information for each change including amounts and dates as indicated
- Indicate any other amendment not listed on the form and specify the change.

Specific Injury Agreement

- Provide the details of any agreement on compensation for specific injuries. Use a separate line for each body part.
- Disfigurement: provide the disfigured body part, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.
- Loss of use: indicate the affected body part, percent of loss, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.
- Hearing Loss: indicate if hearing loss is for left, right or both ears. Specify the type of hearing loss as occupational or traumatic. Provide the percent of loss, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.

Signature Block. Both the employee and a representative for the claims administrator on behalf of the employer must sign this document and date the form.

A copy of the form must be provided to each party and filed with RI Department of Labor and Training.

Revised 12/12/2016